American Physicians
ASSURANCE CORPORATION

Practices That Set The Standard

February 26, 2008

Sent Certified Mail

Michael T. McRaith
Director of Insurance
Illinois Division of Insurance
320 West Washington Street, 4th Floor
Springfield, IL 62676

Attention: Property & Casualty Section
Gayle Neuman

APA's Filing No.: IL-2008-01
NAIC No.: 33006
Company FEIN: 38-2102867

Dear Ms. Neuman:

Subject:	Professional Medical Malpractice Liability
Program:	Health Care Providers Professional Liability Program
Type:	Rate and Rule Filing
Effective Date:	March 1, 2008

This is to advise that American Physicians Assurance Corporation wishes to place on file the below outlined revisions to its Health Care providers Professional Liability Program (HCP-PL). All changes are being disclosed via the updated manual pages and the NAIC transmittal form and this cover letter. The proposed rates with this filing are adequate, not excessive, and not unfairly discriminatory. We are requesting an effective date of March 1, 2008.

The following items are completed and attached:
1. Rate / Rule Review Requirements Checklist
2. NAIC Transmittal Form
3. RF-3 (Duplicate copies attached)
4. Actuarial memorandum
5. Illinois Certification Form for Medical Malpractice rates signed by Kevin Clinton, CEO and Kevin Dyke, Chief Actuary
6. Updated rate / rule manual pages including a final version and a highlighted version noting the changes made since the last major rate / rule filing.
7. Self-addressed stamped envelope to return a copy of the approved filing to my attention.

If you should have any questions, please contact me at 1-800-748-046, extension 6849 or e-mail me at pedgington@apcapital.com. Thank you for your assistance in this matter.

Sincerely,

Patty Edgington

Patty Edgington, AU
Compliance Manager

Enclosures

-5.3%

1301 North Hagadorn Road ▪ PO Box 1471 ▪ East Lansing, MI 48826-1471
1.800.748.0465 ▪ 517.351.1150 ▪ www.apassurance.com

RATE/RULE FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes rate-related items such as Rate; Rule; Rate & Rule; Reference; Loss Cost; Loss Cost & Rule or Rate, etc.)

(Do not refer to the body of the filing for the component/exhibit listing, unless allowed by state.)

1.	**This filing transmittal is part of Company Tracking #**	**IL-2008-01**
2.	**This filing corresponds to form filing number** (Company tracking number of form filing, if applicable)	

☐ Rate Increase XX Rate Decrease ☐ Rate Neutral (0%)

3.	**Filing Method (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

4a. Rate Change by Company (As Proposed)

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change (where required)	Minimum % Change (where required)
American Physicians Assurance Corporation	-5.3%	-5.3%	-2,566,325	1,308	48,421,229	(+)2.3%	(-)44.1%

4b. Rate Change by Company (As Accepted) For State Use Only

Company Name	Overall % Indicated Change (when applicable)	Overall % Rate Impact	Written premium change for this program	# of policyholders affected for this program	Written premium for this program	Maximum % Change	Minimum % Change

5. Overall Rate Information (Complete for Multiple Company Filings only)

		COMPANY USE	STATE USE
5a	**Overall percentage rate indication (when applicable)**	(-)5.3%	
5b	**Overall percentage rate impact for this filing**	(-)5.3%	
5c	**Effect of Rate Filing – Written premium change for this program**	-2,566,325	
5d	**Effect of Rate Filing – Number of policyholders affected**	1,308	

6.	**Overall percentage of last rate revision**	-14.0%
7.	**Effective Date of last rate revision**	3-1-07
8.	**Filing Method of Last filing (Prior Approval, File & Use, Flex Band, etc.)**	File and Use

9.	**Rule # or Page # Submitted for Review**	**Replacement or withdrawn?**	**Previous state filing number, if required by state**
01	Pages IL-1 through IL-5	[ ] New [x] Replacement [ ] Withdrawn	IL-2007-01 (Last major rate revision effective 3-1-07)
02		[ ] New [ ] Replacement [ ] Withdrawn	
03		[ ] New [ ] Replacement [ ] Withdrawn	

Effective March 1, 2007

Pro ty & Casualty Transmittal Docu nt

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only
	a. Date the filing is received:
	b. Analyst:
	c. Disposition:
	d. Date of disposition of the filing:
	e. Effective date of filing:
	New Business
	Renewal Business
	f. State Filing #:
	g. SERFF Filing #:
	h. Subject Codes

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DIVISION OF INSURANCE
SPRINGFIELD

3.	Group Name	Group NAIC #
	APCapital Group, Inc.	0966

4.	Company Name(s)	Domicile	NAIC #	FEIN #	State #
	American Physicians Assurance Corp	Michigan	33006	38-2102867	967543-51

5.	Company Tracking Number	IL-2008-01

Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Patty Edgington, 1301 N. Hagadorn Rd., PO Box 1471, East Lansing, MI 48826-1471	Compliance Manager	800-748-0465, ext 6849 or 517-324-6849	517-333-8232	pedgington@apcapital.com

7.	Signature of authorized filer	Patty Edgington
8.	Please print name of authorized filer	Patty Edgington

Filing information (see General Instructions for descriptions of these fields)

9.	**Type of Insurance (TOI)**	Medical Malpractice 11.000
10.	**Sub-Type of Insurance (Sub-TOI)**	Claims-Made 11.10000
11.	**State Specific Product code(s)(if applicable)[See State Specific Requirements]**	Physicians and Surgeons 11.0023
12.	**Company Program Title** (Marketing title)	Health Care Providers Professional Liability Program
13.	**Filing Type**	[ ] Rate/Loss Cost [ ] Rules [x] Rates/Rules [ ] Forms [ ] Combination Rates/Rules/Forms [ ] Withdrawal[ ] Other (give description)
14.	**Effective Date(s) Requested**	New: 3-1-08 Renewal: 3-1-08
15.	**Reference Filing?**	[ ] Yes [x] No
16.	**Reference Organization** (if applicable)	N/A
17.	**Reference Organization # & Title**	
18.	**Company's Date of Filing**	2-26-08
19.	**Status of filing in domicile**	[ ] Not Filed [ ] Pending [x] Authorized [ ] Disapproved

Property & Casualty Transmittal Document—

20.	**This filing transmittal is part of Company Tracking #**	IL-2008-01

21. Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]

Rate/Rule Manual Pages have been updated to reflect an overall premium level decrease of -5.3%. See actuarial memorandum for complete details and justification for the changes.

In addition, a minor clarification in the manual pages has been made regarding specialty descriptions. The Specialty Description of "Hospitalist/Intensive Care Medicine" has been deleted as it was a duplicate description for code 283. The code and description applicable for code 283 will be the one description of "Intensive Care Medicine/Hospitalist".

22. Filing Fees (Filer must provide check # and fee amount if applicable)
[If a state requires you to show how you calculated your filing fees, place that calculation below]

Check #:
Amount: To be invoiced

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

(215 ILCS 5/155.18)(3) states that medical liability rates shall be certified in such filing by an officer of the company and a qualified actuary that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience.

I, R. Kevin Clinton, a duly authorized officer of American Physicians Assurance Corporation, am authorized to certify on behalf of the Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

I, Kevin M. Dyke, FCAS, MAAA, am authorized to certify on behalf of American Physicians Assurance Corporation, making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

R. Kevin Clinton — 2-19-08

Signature and Title of Authorized Insurance Company Officer — Date

Kevin M. Dyke — 2-20-08

Signature, Title and Designation of Authorized Actuary — Date

Insurance Company FEIN 38-2102867 Filing Number IL-2008-01

Insurer's Address 1301 N. Hagadorn Road, PO Box 1471

City East Lansing State MI Zip Code 48826-1471

Contact Person Information:

-Name and E-mail: Patty Edgington, pedgington@apcapital.com

-Direct Telephone and Fax Number: 517-324-6849 (Direct Phone) 517-333-8232 (Fax)

Illinois

ILLINOIS SUMMARY SHEET

FORM RF-3

Change in Company's premium or rate level produced by rate revision effective: 3-1-08

	(1) Coverage	(2) Annual Premium Volume (Illinois)*	(3) Percent Change (+ or -)**
1.	Automobile Liability		
	Private Passenger		
	Commercial		
2.	Automobile Physical Damage		
	Private Passenger		
	Commercial		
3.	Liability Other than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Workers Compensation		
16.	Other: Medical Malpractice Line of Insurance (health care providers)	48,421,229 estimated	(-)5.3%

Does filing only apply to certain territory (territories or certain classes? If so, specify:

Brief description of filing (if filing follows rates of an advisory organization, specify organization):
This filing revises our specialty rates, territorial plan, increased limits aggregates, professional corporation charges, vicarious limit charges, and updates the manual to be in complete compiance with the rate/rule filing checklist.

* Adjusted to reflect all prior rate changes.

** Change in Company's premium level which will result from application of new rates.

American Physicians Assurance Corporation
Name of Company

Patty Edgington
Patty Edgington, Compliance Manager

Filing# IL-2008-01

Neuman, Gayle

From: Edgington, Patty [PEdgington@thedoctors.com]
Sent: Thursday, January 06, 2011 7:49 AM
To: Neuman, Gayle
Cc: O'Donohue, Michael; Fleming, Bill
Subject: RE: American Physicians Assurance Corp. Filings #IL-2008-01, #IL-2009-04, AND #IL-2010-01

Ms. Neuman,
The filings were put into effect on the indicated dates. Thank you for your assistance.

Patty Edgington, AU
Senior Product Development Analyst
The Doctors Company / American Physicians
pedgington@the doctors.com
800-748-0465 Extension 5849
Direct: 517-324-6849

From: Neuman, Gayle [mailto:Gayle.Neuman@illinois.gov]
Sent: Monday, January 03, 2011 3:33 PM
To: Edgington, Patty
Subject: American Physicians Assurance Corp. Filings #IL-2008-01, #IL-2009-04, AND #IL-2010-01

Ms. Edgington,

The Department of Insurance has now completed its review of the filings referenced above. Originally, American Physicians Assurance Corporation requested the filings be effective March 1, 2008 (#IL-2008-01), July 1, 2009 (#IL-2009-04), and March 1, 2010 (#IL-2010-01). Were these filings put in effect on the indicated dates or do you wish to have a different effective date(s)?

Your prompt response is appreciated.

Gayle Neuman
Illinois Department of Insurance
Property & Casualty Compliance
(217) 524-6497

Please refer to the Property & Casualty Review Checklists before submitting any filing. The checklists can be accessed through the Department's website at www.insurance.illinois.gov.

penalties under federal and/or state law. If you received this e-mail in error, please notify the sender immediately and permanently delete this e-mail.

K. Corporate Entity Coverage

Under Countrywide Corporate Entity Coverage Rule, Item B. Organization Coverage Charge – Separate Limits, sub item 3. is replaced with the following:

3.

# of Insureds	Charge
2-5	15.0%
6-9	12.0%
10-19	9.0%
20 or more	7.0%

L. Part-Time Rule

Under Countrywide Rule VI. Special Rating Rules, Item A. Part Time is replaced with the following:

A. Part Time: 60% of the otherwise applicable rate applies to physicians (see eligibility requirements under General Rules) with American Physicians insured exposure averaging 20 hours or less per week. If evidence of insurance is provided for any professional liability exposure insured by any other carrier, that other exposure would be excluded from the American Physicians policy. Other credits may be reduced due to lower premiums with this rating.

XIII. Merit Rating

In order to be eligible for any merit-rating plan, the incurred loss ratio over the last 10 years shall not exceed **135%**. The total credit that may be applied under the Claims-Free Credit Rule is **-15%** and the total credit/debit that may be applied under the Schedule Rating Plan is +/- **35%.**

A. Claim-Free Credit
See countrywide manual Section X. Merit Rating, Rule A. for the underwriting criteria. Below is the Claim-Free Credit Schedule for use in Illinois:

1. Credit Schedule:

Years of Claims-Free Experience	Credit
Three to Five Years	5%
Six to Seven Years	10%
Eight or More Years	15%

B. Schedule Rating Plan

The premium may be credited or debited based on the total of credits and debits derived from the following "risk characteristics" schedule. The maximum allowable credit/debit for the Schedule Rating Plan is **+/- 35%.**

	Maximum Credit	Maximum Debit
1. Professional Skills, Quality of Care Use of a recognized system of clinical guidelines. Relevant board certification. Accreditation status by a recognized regulatory body. The provision of medical care limited to qualified individuals. Continuing education of all professional staff beyond what is required by state licensing regulation. Maintenance of premises and equipment.	10%	10%
2. Patient Rapport Length of service and reputation in community. Established policies and procedures for patient services. Cooperation with the Company claims management and resolution procedures.	10%	10%
3. Record Keeping A well-maintained patient record system in place: thorough documentation of patient care and interaction; follow-up system for diagnostic studies, consultation and appointments.	10%	10%
4. Risk Characteristics a. Documented successful completion of an approved office risk analysis/communication skills assessment/risk management on-site visit and/or education program, including an appropriate response to recommendations made. b. Documented attendance at an approved risk management seminar, or successful completion of an approved risk management correspondence course.	5%	5%

XIV. Quarterly Installment Option and Monthly Installment Option

American Physicians offers the following: (does not apply to Claims-Made Reporting Period Extensions ("tail coverage").

4-pay (quarterly)	25% down payment	3 equal installments (Due 4th, 7th, and 10th months).
9-pay (monthly)	15% down payment	8 equal installments (Due 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, and 9th months).

- A $10 installment fee will be applied to all payment plans/per installment. No interest will be charged.

XV. Deductibles

See Countrywide Manual, Section V. for underwriting criteria.
Item C. from the Deductible section in the Countrywide Manual is deleted and replaced with the following: Deductible factors are applied to the $1,000,000/$4,000,000 base rate, Section IV, Rating Steps, Item D to derive the deductible credit amount.

Deductible Amount Per Incident	Indemnity Only Factor	Indemnity and Defense Factor
$5,000	.01	.03
$10,000	.03	.05
$15,000	.04	.08
$25,000	.07	.12
$30,000	.08	.13
$50,000	.12	.19
$75,000	.16	.25
$100,000	.19	.30
$200,000	.27	.43

XVI. Risk Management Activities Discounts

See Section XIII. Merit Rating, Rule B., Schedule Rating Plan, sub item 4 – Risk Characteristics on page IL-9 for the Underwriting Criteria.

XVII. Consent to Rate

Under Countrywide Rules, Rule XI. Consent to Rate is deleted in its entirety.

XII. RATES, STATE RULES EXCEPTIONS--Illinois HIGHLIGHTED VERSION

A. Illinois Rating Territories

Territory Code	Territory Description	Territory Factor
1	Cook, Madison and St. Clair Counties	1.000
2	Jackson, Vermilion and Will Counties	0.890
3	DuPage, Kane, Lake, McHenry and Winnebago Counties	0.800
4	Champaign, Macon and Sangamon Counties	0.630
5	Bureau, Coles, DeKalb, Kankakee, LaSalle, Ogle and Randolph Counties	0.720
6	Remainder of State	0.530
7	Peoria County	0.470

B. Mature Claims-Made Rates - Countrywide Manual Section II. General Rules, Rule A. Rates – is amended to read: Premiums are calculated by using the mature claims-made base rates, as shown below with limits of $1,000,000/$4,000,000 and by applying applicable claims-made maturity factors or other coverage option factors.

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
229		Addictionology	18,703	16,645	14,962	11,783	13,466	9,912	8,790
230		Aerospace Medicine	24,231	21,565	19,385	15,265	17,446	12,842	11,388
254		Allergy	17,349	15,441	13,879	10,930	12,491	9,195	8,154
151		Anesthesiology	41,530	36,962	33,224	26,164	29,902	22,011	19,519
196		Anesthesiology – Pain Management	41,530	36,962	33,224	26,164	29,902	22,011	19,519
255		Cardiovascular Disease – No Surgery	28,631	25,482	22,905	18,038	20,615	15,175	13,457
281		Cardiovascular Disease - Minor Surgery	59,659	53,097	47,727	37,585	42,955	31,619	28,040
256		Dermatology	20,790	18,503	16,632	13,098	14,969	11,019	9,771
282		Dermatology – Minor Surgery	37,497	33,373	29,998	23,623	26,998	19,874	17,624
237		Diabetes – No Surgery	26,946	23,982	21,557	16,976	19,401	14,281	12,665
271		Diabetes – Minor Surgery	39,821	35,441	31,857	25,087	28,671	21,105	18,716
102	S	Emergency Medicine – No Major Surgery	99,326	88,400	79,461	62,575	71,515	52,643	46,683
238		Endocrinology – No Surgery	25,678	22,853	20,542	16,177	18,488	13,609	12,068
272		Endocrinology – Minor Surgery	37,945	33,771	30,356	23,906	27,321	20,111	17,834

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
420		Family/General Practitioners – No Surgery	34,973	31,126	27,978	22,033	25,181	18,536	16,437
421		Family/General Practitioners – Minor Surgery	46,692	41,556	37,354	29,416	33,618	24,747	21,945
521		Family/General Practitioners –Minor Surgery – 0 to 24 deliveries	47,432	42,215	37,946	29,882	34,151	25,139	22,293
240		Forensic or Legal Medicine	16,963	15,097	13,570	10,686	12,213	8,990	7,972
241		Gastroenterology – No Surgery	43,206	38,454	34,565	27,220	31,109	22,899	20,307
274		Gastroenterology – Minor Surgery	46,076	41,007	36,860	29,028	33,174	24,420	21,655
231		General Preventive Medicine – No Surgery	15,933	14,180	12,746	10,038	11,472	8,444	7,488
243		Geriatrics – No Surgery	27,381	24,369	21,905	17,250	19,714	14,512	12,869
276		Geriatrics – Minor Surgery	40,464	36,013	32,371	25,492	29,134	21,446	19,018
244		Gynecology – No Surgery	26,562	23,640	21,250	16,734	19,125	14,078	12,484
277		Gynecology – Minor Surgery	42,589	37,905	34,072	26,831	30,664	22,572	20,017
245		Hematology – No Surgery	34,973	31,126	27,978	22,033	25,181	18,536	16,437
278		Hematology – Minor Surgery	49,603	44,147	39,682	31,250	35,714	26,290	23,313
~~283~~		~~Hospitalist/Intensive Care Medicine~~	~~38,772~~	~~34,507~~	~~31,018~~	~~24,426~~	~~27,916~~	~~20,549~~	~~18,223~~
232		Hypnosis	16,562	14,740	13,250	10,434	11,925	8,778	7,784
246		Infectious Diseases – No Surgery	50,711	45,132	40,568	31,948	36,512	26,877	23,834
279		Infectious Diseases – Minor Surgery	79,933	71,140	63,946	50,358	57,551	42,364	37,568
283		Intensive Care Medicine/Hospitalist	38,772	34,507	31,018	24,426	27,916	20,549	18,223
257		Internal medicine – No Surgery	41,066	36,548	32,853	25,871	29,567	21,765	19,301
284		Internal medicine – Minor Surgery	53,464	47,583	42,771	33,682	38,494	28,336	25,128
258		Laryngology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
285		Laryngology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278
801		Manipulative Medicine	17,450	15,530	13,960	10,993	12,564	9,248	8,201
471		Neonatology - No Surgery	60,567	53,905	48,454	38,157	43,608	32,100	28,466
476		Neonatology – Minor Surgery	75,710	67,382	60,568	47,697	54,511	40,126	35,584
259		Neoplastic Diseases – No Surgery	35,523	31,615	28,418	22,379	25,576	18,827	16,696
260		Nephrology – No Surgery	31,476	28,014	25,181	19,830	22,663	16,682	14,794
287		Nephrology – Minor Surgery	46,515	41,399	37,212	29,305	33,491	24,653	21,862
261		Neurology – No Surgery	42,104	37,473	33,683	26,526	30,315	22,315	19,789
288		Neurology – Minor Surgery	49,989	44,490	39,991	31,493	35,992	26,494	23,495
262		Nuclear Medicine	25,581	22,767	20,465	16,116	18,418	13,558	12,023
248		Nutrition	15,022	13,369	12,017	9,464	10,816	7,961	7,060
233		Occupational Medicine	20,192	17,971	16,154	12,721	14,538	10,702	9,490
473		Oncology – No Surgery	35,523	31,615	28,418	22,379	25,576	18,827	16,696
286		Oncology – Minor Surgery	43,745	38,933	34,996	27,559	31,496	23,185	20,560
263		Ophthalmology – No Surgery	23,763	21,149	19,010	14,971	17,109	12,594	11,168
289		Ophthalmology – Minor Surgery	25,823	22,983	20,659	16,269	18,593	13,686	12,137
264		Otology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
290		Otology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
265		Otorhinolaryngology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
291		Otorhinolaryngology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278
266		Pathology – No Surgery	27,602	24,566	22,082	17,390	19,874	14,629	12,973
292		Pathology – Minor Surgery	48,250	42,943	38,600	30,398	34,740	25,573	22,678
267		Pediatrics – No Surgery	27,698	24,651	22,159	17,450	19,943	14,680	13,018
293		Pediatrics – Minor Surgery	41,229	36,693	32,983	25,974	29,685	21,851	19,377
234		Pharmacology	24,231	21,565	19,385	15,265	17,446	12,842	11,388
235		Physiatry or Physical Medicine and Rehabilitation	17,450	15,530	13,960	10,993	12,564	9,248	8,201
437		Physicians – No Major Surgery – acupuncture	43,745	38,933	34,996	27,559	31,496	23,185	20,560
802		Physicians – No Major Surgery – Sclerotherapy	47,672	42,428	38,138	30,034	34,324	25,266	22,406
431		Physicians – No Major Surgery – shock therapy	47,672	42,428	38,138	30,034	34,324	25,266	22,406
268		Physicians – not otherwise classified – no surgery	28,039	24,955	22,431	17,665	20,188	14,861	13,178
294		Physicians – not othewise classified – minor surgery	43,745	38,933	34,996	27,559	31,496	23,185	20,560
249		Psychiatry	19,577	17,424	15,662	12,334	14,096	10,376	9,201
250		Psychoanalysis	18,296	16,283	14,637	11,526	13,173	9,697	8,599
251		Psychosomatic Medicine	14,770	13,146	11,816	9,305	10,635	7,828	6,942
236		Public Health	16,963	15,097	13,570	10,686	12,213	8,990	7,972
269		Pulmonary Diseases – No Surgery	36,216	32,232	28,972	22,816	26,075	19,194	17,021
298		Pulmonary Diseases – Minor Surgery	61,753	54,960	49,403	38,905	44,462	32,729	29,024
253	S	Radiology – diagnostic – No Surgery	43,268	38,508	34,614	27,259	31,153	22,932	20,336
280	S	Radiology – diagnostic – Minor Surgery	65,837	58,595	52,670	41,477	47,403	34,894	30,943
425	S	Radiology – Therapeutic	48,910	43,530	39,128	30,813	35,215	25,922	22,988
252		Rheumatology – No Surgery	26,236	23,350	20,989	16,529	18,890	13,905	12,331
247		Rhinology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
270		Rhinology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278
166	S	Surgery – Abdominal	99,148	88,242	79,318	62,463	71,386	52,548	46,599
101	S	Surgery – Broncho-esophagology	50,336	44,799	40,269	31,712	36,242	26,678	23,658
141	H	Surgery – Cardiac	154,358	137,379	123,486	97,245	111,138	81,810	72,548
150	H	Surgery – Cardiovascular Disease	141,068	125,550	112,854	88,873	101,569	74,766	66,302
115	S	Surgery – Colon and Rectal	66,351	59,052	53,081	41,801	47,773	35,166	31,185
472	S	Surgery – Dermatology	50,971	45,365	40,777	32,112	36,699	27,015	23,957
157	S	Surgery – Emergency Medicine	110,140	98,025	88,112	69,388	79,301	58,374	51,766
103	S	Surgery – Endocrinology	43,943	39,109	35,154	27,684	31,639	23,290	20,653
117	S	Surgery – Family/General Practice	64,564	57,462	51,651	40,676	46,486	34,219	30,345
104	S	Surgery – Gastroenterology	61,371	54,620	49,096	38,663	44,187	32,526	28,844
143	S	Surgery – General – not otherwise classified	92,067	81,939	73,653	58,002	66,288	48,795	43,271
105	S	Surgery – Geriatrics	64,705	57,587	51,764	40,764	46,587	34,293	30,411
167	H	Surgery – Gynecology	71,422	63,565	57,137	44,996	51,424	37,854	33,568
169	S	Surgery – Hand	64,413	57,328	51,530	40,580	46,377	34,139	30,274
170	S	Surgery – Head and Neck	79,367	70,636	63,493	50,001	57,144	42,064	37,302
106	S	Surgery - Laryngology	59,041	52,546	47,233	37,196	42,509	31,292	27,749

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
474	H	Surgery – Neonatology or Pediatrics	106,511	94,794	85,208	67,102	76,688	56,451	50,060
107	S	Surgery – Neoplastic	55,916	49,765	44,733	35,227	40,260	29,636	26,281
108	S	Surgery – Nephrology	59,393	52,860	47,514	37,418	42,763	31,478	27,915
152	H	Surgery – Neurology	244,420	217,533	195,536	153,984	175,982	129,542	114,877
168	H	Surgery – Obstetrics	128,387	114,264	102,709	80,884	92,438	68,045	60,342
153	H	Surgery – Obstetrics – Gynecology	128,387	114,264	102,709	80,884	92,438	68,045	60,342
560	H	Surgery – Obstetrics – Gynecology – 0 to 49 deliveries	102,715	91,416	82,172	64,710	73,955	54,439	48,276
561	H	--50 to 69 deliveries	105,919	94,268	84,735	66,729	76,262	56,137	49,782
562	H	--70 to 89 deliveries	109,127	97,123	87,302	68,750	78,572	57,837	51,290
563	H	-- 90 to 109 deliveries	115,548	102,838	92,438	72,795	83,195	61,240	54,308
564	H	--110 to 129 deliveries	121,970	108,553	97,576	76,841	87,818	64,644	57,326
565	H	--130 to 149 deliveries	128,387	114,264	102,709	80,884	92,438	68,045	60,342
566	H	--150 to 169 deliveries	141,226	125,691	112,980	88,972	101,682	74,850	66,376
567	H	--170 to 189 deliveries	154,065	137,118	123,252	97,061	110,927	81,654	72,410
568	H	--190 to 209 deliveries	166,902	148,542	133,521	105,148	120,169	88,458	78,444
569	H	--210 to 229 deliveries	179,743	159,971	143,794	113,238	129,415	95,264	84,479
570	H	--230 to 249 deliveries	192,579	171,395	154,063	121,325	138,657	102,067	90,512
571	H	--250 to 269 deliveries	205,418	182,822	164,334	129,413	147,901	108,871	96,546
572	H	--270 to 289 deliveries	218,259	194,250	174,607	137,503	157,146	115,677	102,582
573	H	--290 to more deliveries	231,095	205,675	184,876	145,590	166,389	122,481	108,615
114	S	Surgery – Ophthalmology	45,753	40,721	36,603	28,825	32,942	24,249	21,504
804	S	Surgery – Ophthalmology – Plastic	59,866	53,281	47,893	37,716	43,104	31,729	28,137
154	H	Surgery – Orthopedic	157,096	139,816	125,677	98,971	113,109	83,261	73,835
164	H	Surgery – Orthopedic – without procedures on the back	115,759	103,026	92,607	72,928	83,347	61,352	54,407
158	S	Surgery – Otology	59,041	52,546	47,233	37,196	42,509	31,292	27,749
159	S	Surgery – Otorhinolaryngology	59,041	52,546	47,233	37,196	42,509	31,292	27,749
156	H	Surgery – Plastic – not otherwise classified	94,692	84,276	75,753	59,656	68,178	50,187	44,505
155	S	Surgery – Otorhinolaryngology	89,669	79,805	71,735	56,491	64,561	47,524	42,144
160	S	Surgery – Rhinology	59,041	52,546	47,233	37,196	42,509	31,292	27,749
144	H	Surgery – Thoracic	129,202	114,990	103,362	81,397	93,026	68,477	60,725
171	H	Surgery – Traumatic	128,187	114,086	102,550	80,758	92,295	67,939	60,248
145	S	Surgery – Urological	60,014	53,412	48,011	37,809	43,210	31,807	28,207
146	H	Surgery – Vascular	146,709	130,571	117,367	92,427	105,630	77,756	68,953
424		Urgent Care Medicine	34,973	31,126	27,978	22,033	25,181	18,536	16,437

Note: When $2,000,000/$4,000,000 Increased Limits Factor (ILF) is requested for a specialty code that displays an alpha code, either **S** or **H,** use the corresponding ILF factor as displayed in Rule F.

C. Mature Claims-Made Rates – Dentists

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
212		Dental Surgeons – Oral or Maxillofacial – Engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia	38,655	34,403	30,924	24,353	27,832	20,487	18,168
210		Dentists – Minor Surgery	19,329	17,202	15,463	12,177	13,917	10,244	9,084
211		Dentists – No Surgery - not otherwise classified	7,731	6,881	6,185	4,871	5,566	4,097	3,634

D. Mature Claims-Made Rates – Healthcare Facilities

1. Emergency Room Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
S	Emergency Room Groups ("Per 100 patient visits" basis). Separate limits per member physician/healthcare professional may be purchased for an additional 20% charge of the "per patient visit" premium.	1,993	1,774	1,594	1,256	1,435	1,056	937

2. Urgent Care Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
	Urgent Care Groups ("Per 100 patient visits" basis). Separate limits per member physician/healthcare professional may be purchased for an additional 20% charge of the "per patient visit" premium.	560	498	448	353	403	297	263

3. Outpatient Surgery Centers*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
S	Outpatient Surgery Centers (Surgicenters) ("Per 100 patient visits" basis). All physicians must be separately insured by American Physicians in order to provide coverage for the outpatient surgery center.	2,833	2,521	2,266	1,785	2,040	1,501	1,331

4. Additional Healthcare Facility Rates (per $1000 receipts basis)*

ILFs Alpha Code	Specialty Description/Code	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
	X-Ray / Imaging Laboratory/Code 88526	7.43	7.43	7.43	7.43	7.43	7.43	7.43

*Note: Minimum premium for each Facility Policy in Section D., Item 1, 2, 3, and 4 is $2,500.

E. Premium Charges for Vicarious, Shared and Separate Limits
Under Countrywide Rule IX., Item D., Premium Charges for Vicarious, Shared and Separate Limits is replaced in its entirety with the following:

Specialty Code	Healthcare Professional	Vicarious Limit Charge	Shared Limit Charge	Separate Limit Charge
411	Chiropractor	0%	35% of class 420	70% of class 420
452	Nurse Anesthetist	0%	7.5% of class 151	15% of class 151
962	Nurse Midwife	0%	25% of class 153	50% of class 153
963	Nurse Practitioner	0%	7.5% of class 420	15% of class 420
942	Perfusionist	0%	7.5% of class 420	15% of class 420
807	Physician Assistant	0%	7.5% of class 420	15% of class 420
943	Podiatrist/incl. surg.	0%	40% of class 143	50% of class 143
944	Podiatrist – no surg.	0%	35% of class 420	70% of class 420
946	Psychologist	0%	5% of class 249	10% of class 249
808	Surgeon Assistant	0%	7.5% of class 420	15% of class 420

F. Higher limits of liability may be purchased at premiums derived by applying the following factors to the $1,000,000/$4,000,000 rates:

Higher Limits of Liability	All Other Physicians and Dentists	Emergency Medicine, Radiologists, All Other Surgery **(S)**	Selected Surgical Specialties **(H)**
$2,000,000/$4,000,000	1.344	1.418	1.460

For higher Limits of Liability – Refer to Company

G. Limits that are less than these $1,000,000/$4,000,000 may be purchased at premiums derived from applying the following decreased limit factors to the $1,000,000/$4,000,000 rates (not including any credit applied for a deductible):

Limits of Liability	All Physicians, Surgeons, and Dentists
$100,000/$400,000	0.480
$200/000/$800,000	0.620
$250,000/$1,000,000	0.665
$300,000/$1,200,000	0.700
$500,000/$2,000,000	0.790
$750,000/$3,000,000	0.920
$1,000,000/$2,000,000	0.980
$1,000,000/$4,000,000	1.000

H. Claims-Made Maturity Factors

Note: If the retroactive date falls on a date other than the anniversary date, a factor will be used that is pro-rating the two applicable maturity factors. These factors are applied to the mature claims-made base rates.

First Year	0.25
Second Year	0.40
Third Year	0.75
Fourth Year	0.90
Fifth Year	0.95
Sixth Year	0.98
Mature	1.00

I. Reporting Period Extension Factors

Claims-made reporting period extension(s) ("tail" coverage) are offered (unless coverage is automatically provided within the terms of the policy) to any insured whose coverage is terminated for any reason.

1. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor displayed below to the annual expiring premium.

2. Alternatively, three extensions may be purchased as of the policy termination and the next two anniversaries of that termination. Separate limits apply for each of the three extensions. The final extension is an unlimited extension. Premiums for each extension are 33.3% of the rate applicable to the single unlimited extension (1.).

J. Factors are applied to the claims-made rate applicable to the annual expiring policy at the time the extended reporting endorsement is offered.

First Year	4.00
Second Year	3.88
Third Year	2.40
Fourth Year	2.11
Fifth Year	2.05
Sixth Year	2.01
Mature	1.97

K. Corporate Entity Coverage

Under Countrywide Corporate Entity Coverage Rule, Item B. Organization Coverage Charge – Separate Limits, sub item 3. is replaced with the following:

3.

# of Insureds	Charge
2-5	15.0%
6-9	12.0%
10-19	9.0%
20 or more	7.0%

L. Part-Time Rule

Under Countrywide Rule VI. Special Rating Rules, Item A. Part Time is replaced with the following:

A. Part Time: 60% of the otherwise applicable rate applies to physicians (see eligibility requirements under General Rules) with American Physicians insured exposure averaging 20 hours or less per week. If evidence of insurance is provided for any professional liability exposure insured by any other carrier, that other exposure would be excluded from the American Physicians policy. Other credits may be reduced due to lower premiums with this rating.

XIII. Merit Rating

In order to be eligible for any merit-rating plan, the incurred loss ratio over the last 10 years shall not exceed **135%**. The total credit that may be applied under the Claims-Free Credit Rule is **-15%** and the total credit/debit that may be applied under the Schedule Rating Plan is **+/- 35%.**

A. Claim-Free Credit
See countrywide manual Section X. Merit Rating, Rule A. for the underwriting criteria. Below is the Claim-Free Credit Schedule for use in Illinois:

1. Credit Schedule:

Years of Claims-Free Experience	Credit
Three to Five Years	5%
Six to Seven Years	10%
Eight or More Years	15%

B. Schedule Rating Plan

The premium may be credited or debited based on the total of credits and debits derived from the following "risk characteristics" schedule. The maximum allowable credit/debit for the Schedule Rating Plan is **+/- 35%.**

	Maximum Credit	Maximum Debit
1. Professional Skills, Quality of Care Use of a recognized system of clinical guidelines. Relevant board certification. Accreditation status by a recognized regulatory body. The provision of medical care limited to qualified individuals. Continuing education of all professional staff beyond what is required by state licensing regulation. Maintenance of premises and equipment.	10%	10%
2. Patient Rapport Length of service and reputation in community. Established policies and procedures for patient services. Cooperation with the Company claims management and resolution procedures.	10%	10%
3. Record Keeping A well-maintained patient record system in place: thorough documentation of patient care and interaction; follow-up system for diagnostic studies, consultation and appointments.	10%	10%
4. Risk Characteristics a. Documented successful completion of an approved office risk analysis/communication skills assessment/risk management on-site visit and/or education program, including an appropriate response to recommendations made. b. Documented attendance at an approved risk management seminar, or successful completion of an approved risk management correspondence course.	5%	5%

XIV. Quarterly Installment Option and Monthly Installment Option

American Physicians offers the following: (does not apply to Claims-Made Reporting Period Extensions ("tail coverage").

4-pay (quarterly)	25% down payment	3 equal installments (Due 4th, 7th, and 10th months).
9-pay (monthly)	15% down payment	8 equal installments (Due 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, and 9th months).

- A $10 installment fee will be applied to all payment plans/per installment. No interest will be charged.

XV. Deductibles

See Countrywide Manual, Section V. for underwriting criteria.
Item C. from the Deductible section in the Countrywide Manual is deleted and replaced with the following: Deductible factors are applied to the $1,000,000/$4,000,000 base rate, Section IV, Rating Steps, Item D to derive the deductible credit amount.

Deductible Amount Per Incident	Indemnity Only Factor	Indemnity and Defense Factor
$5,000	.01	.03
$10,000	.03	.05
$15,000	.04	.08
$25,000	.07	.12
$30,000	.08	.13
$50,000	.12	.19
$75,000	.16	.25
$100,000	.19	.30
$200,000	.27	.43

XVI. Risk Management Activities Discounts

See Section XIII. Merit Rating, Rule B., Schedule Rating Plan, sub item 4 – Risk Characteristics on page IL-9 for the Underwriting Criteria.

XVII. Consent to Rate

Under Countrywide Rules, Rule XI. Consent to Rate is deleted in its entirety.

Contact Person:
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217-524-6497
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Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Effective as of 8/25/06

From: Patty Edgington at American Physicians Assurance Corp, NAIC #33006, Fein #38-2102867

Co Filing #IL-2008-01

Line(s) of Business	Code(s)	
_x__**MEDICAL MALPRACTICE**	**11.0000**	***This checklist is for rate/rule
_x_Claims Made	11.10000	**filings only.**
___Occurrence	11.2000	**See separate form checklist.**

Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)	Line(s) of Insurance	Code(s)
___Acupuncture	11.0001	___Hospitals	11.0009	___Optometry	11.0019
___Ambulance Services	11.0002	___Professional Nurses	11.0032	___Osteopathy	11.0020
___Anesthetist	11.0031	___Nurse – Anesthetists	11.0010	___Pharmacy	11.0021
___Assisted Living Facility	11.0033	___Nurse – Lic. Practical	11.0011	___Physical Therapy	11.0022
___Chiropractic	11.0003	___Nurse – Midwife	11.0012	_x_Physicians & Surgeons	11.0023
___Community Health Center	11.0004	___Nurse – Practitioners	11.0013	___Physicians Assistants	11.0024
___Dental Hygienists	11.0005	___Nurse – Private Duty	11.0014	___Podiatry	11.0025
___Dentists	11.0030	___Nurse – Registered	11.0015	___Psychiatry	11.0026
___Dentists – General Practice	11.0006	___Nursing Homes	11.0016	___Psychology	11.0027
___Dentists – Oral Surgeon	11.0007	___Occupational Therapy	11.0017	___Speech Pathology	11.0028
___Home Care Service Agencies	11.0008	___Ophthalmic Dispensing	11.0018	___Other	11.0029

Illinois Insurance Code Link	Illinois Compiled Statutes Online	
Illinois Administrative Code Link	Administrative Regulations Online	
Product Coding Matrix Link	Product Coding Matrix	
NAIC Uniform Transmittal Form	50 IL Adm. Code 929 NAIC Uniform Transmittal Form	If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in the "Cover Letter & Explanatory Memorandum" section below are properly included.
NAIC Self-Certification Pilot Program	Newsletter Article regarding Division's Participation Self-Certification form	If an authorized company officer completes the Self-Certification form, and submits such form as the 1st page of the filing, the Division will expedite review of the filing ahead of all other filings received to date. The Division will track company compliance with the laws, regulations, bulletins, and this checklist and report such information to the NAIC.
Location of Standard within Filing Column	See checklist format below.	To expedite review of your filing, use this column to indicate location of the standard within the filing (e.g. page #, section title, etc.)
Description of Review Standards Requirements Column	See checklist format below.	These brief summaries do not include all requirements of all laws, regulations, bulletins, or requirements, so review actual law, regulation, bulletin, or requirement for details to ensure that forms are fully compliant before filing with the Division of Insurance.

Column		

FILING REQUIREMENTS FOR FORM FILINGS	REFERENCE	DESCRIPTION OF REVIEW STANDARD REQUIREMENT	LOCATION OF STANDARD WITHIN FILING
See separate form filing checklist.		To assist insurers in submitting compliant medical liability rate/rule filings as a result of newly-passed PA94-677 (SB475), the Division has created this separate, comprehensive rate/rule filing checklist for medical liability filings. Please see the separate form filing checklist for requirements related to medical liability forms.	N/A – This is a rate/rule filing.
GENERAL FILING REQUIREMENTS FOR ALL RATE/RULE FILINGS			
LINE OF AUTHORITY			
Must have proper Class and Clause authority to conduct this line of business in Illinois.	215 ILCS 5/4 List of Classes/Clauses	To write Medical Liability insurance in Illinois, companies must be licensed to write: 1. Class 2, Clause (c)	APA Certificate of Authority grants class 2, clause c authority, COA#967543-51
RATES AND RULES REQUIRED TO BE FILED			
Rates/Rules Must be Filed Separately from Forms			
Insurers shall make separate filings for rate/rules and for forms/endorsements, etc.		The laws and regulations for medical liability forms/endorsements and the laws for medical liability rates/rules are different and each must be reviewed according to its own set of laws/regulations/procedures. Therefore, insurers are required to file forms and rates/rules separately. For requirements regarding form filings, see separate form filing checklist.	This is a rate filing effective 3-1-08.
New Insurers			
New insurers must file their rates, rules, plans for gathering statistics, etc. upon commencement of business.	215 ILCS 5/155.18 50 IL Adm. Code 929	"New Insures" are insurers who are: • New to Illinois. • New writers of medical liability insurance in Illinois. • Writing a new Line of Insurance listed on Page 1 of this checklist, New insurers must file the following:	Not applicable with this filing. We are not a new insurer.

		a) Medical liability insurance rate manual, including all rates. b) Rules, including underwriting rule manuals which contain rules for applying rates or rating plans, c) Classifications and other such schedules used in writing medical liability insurance. d) Statement regarding whether the insurer: • Has its own plan for the gathering of medical liability statistics; or • Reports its medical liability statistics to a statistical agent (and if so, which agent). The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	
Amendments to Initial Rate/Rule Filings			
After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules, or advise of changes to statistical plans, as often as they are amended.	215 ILCS 5/155.18 50 IL Adm. Code 929	After a new insurer has filed the rates/rules/information described above, insurers must file rates/rules/rating schedules (as described above for new business) as often as such filings are changed or amended, or when any new rates or rules are added. Any change in premium to the company's insureds as a result of a change in the company's base rates or a change in its increased limits factors shall constitute a change in rates and shall require a filing with the Director. Insurers shall also advise the Director if its plans for the gathering of statistics has changed, or if the insurer has changed statistical agents. The Director, at any time, may request a copy of the insurer's statistical plan or request the insurer to provide written verification of membership and reporting status from the insurer's reported statistical agency. Insurers are instructed to review all requirements in this checklist, including the requirements for applicable actuarial documentation, as well as all medical liability laws and regulations, to ensure that the filing contains all essential elements before submitting the filing to the Division.	Rate/rule manual pages have been updated and actuarial documentation is attached.
EFFECTIVE DATES OF RATE/RULE FILINGS			
Illinois is "file and use"	215 ILCS 5/155.18	A rate/rating plan/rule filing shall go into effect no	Filing is being mailed

for medical liability rates and rules.	50 IL Adm. Code 929	earlier than the date the filing is received by the Division of Insurance, Property & Casualty Compliance Section, except as otherwise provided in Section 155.18.	certified mail on 2-26-08 to be effective 3-1-08.
ADOPTIONS OF ADVISORY ORGANIZATION FILINGS			
Insurer must file all rates and rules on its own behalf.	50 IL Adm. Code 929	Although Rule 929 allows for insurers to adopt advisory organization rule filings, advisory organizations no longer file rules in Illinois.	We are filing on our own behalf.
COPIES, RETURN ENVELOPES, ETC.			
Requirement for duplicate copies and return envelope with adequate postage.	50 IL Adm. Code 929	Insurers that desire a stamped returned copy of the filing or submission letter must submit a duplicate copy of the filing/letter, along with a return envelope large enough and containing enough postage to accommodate the return filing.	Duplicate copy of filing in addition to return envelope with adequate postage is attached.
COVER LETTER & EXPLANATORY MEMORANDUM			
Two copies of a submission letter are required, and the submission letter must contain the information specified. "Me too" filings are not allowed. Use of NAIC Uniform Transmittal form is acceptable as long as all required information is included.	215 ILCS 5/155.18 50 IL Adm. Code 929 Company Bulletin 88-53 Actuarial Certification Form NAIC Uniform Transmittal Form	All filings must be accompanied by a submission letter which includes all of the following information: 1) Exact name of the company making the filing. 2) Federal Employer Identification Number (FEIN) of the company making the filing. 3) Unique filing identification number – may be alpha, numeric, or both. Each filing number must be unique within a company and may not be repeated on subsequent filings. If filing subsequent revisions to a pending filing, use the same filing number as the pending filing or the revision(s) will be considered a new filing. 4) Identification of the classes of medical liability insurance to which the filing applies (for identifying classes, refer to Lines of Insurance shown on Page 1 of this checklist, in compliance with the NAIC Product Coding Matrix). 5) Notification of whether the filing is new or supersedes a present filing. If filing supersedes a present filing, insurer must identify all changes in superseding filings, and all superseded filings, including the following information: • Copy of the complete rate/rule manual section(s) being changed by the filing with all changes clearly highlighted or otherwise identified. • Written statement that all changes made to the superseded filing have been disclosed. • List of all pages that are being completely superseded or replaced with new pages. • List of pages that are being withdrawn and not	Submission letter attached with all items including the NAIC transmittal document. Included in submission letter and NAIC transmittal form. Included in submission letter and NAIC transmittal form. Included in cover letter and NAIC transmittal form. Included in NAIC transmittal form. Included in cover letter and NAIC transmittal form.

		being replaced. • List of new pages that are being added to the superseded filing. • Copies of all manual pages that are affected by the new filing, including but not limited to subsequent pages that are amended solely by receiving new page numbers. 6) Effective date of use. 7) Actuarial certification (see Actuarial Certification section below). Insurers may use their own form or may use the sample form developed by the Division. 8) Statement that the insurer, in offering, administering, or applying the filed rate/rule manual and/or any amended provisions, does not unfairly discriminate. Companies under the same ownership or general management are required to make separate, individual company filings. Company Group ("Me too") filings are unacceptable. If insurers wish to use the NAIC Uniform Transmittal form in lieu of a cover letter/explanatory memorandum, the Division will accept such form, as long as all information required in this section is properly included.	Included in cover letter and NIAC transmittal form. The signed actuarial certification form is attached. Included in cover letter and NAIC transmittal form. Not applicable with this filing.
FORM RF-3 Summary Sheet			
For any rate change, duplicate copies of Form RF-3 must be filed, no later than the effective date.	50 IL Adm. Code 929 Form RF-3 Summary Sheet	For any rate level change, insurers must file two copies of Form RF-3 (Summary Sheet) which provides information on changes in rate level based on the company's premium volume, rating system, and distribution of business with respect to the classes of medical liability insurance to which the rate revision applies. Such forms must be received by the Division's Property & Casualty Compliance Section no later than the stated effective date of use. Insurers must report the rate change level and premium volume amounts on the "Other" Line and insert the words "Medical Liability" on the "Other" descriptive line. Do not list the information on the "Other Liability" line. If the Medical Liability premium is combined with any other Lines of Business (e.g. CGL, commercial property, etc.), the insurer must report the effect of rate changes to each line separately on the RF-3, indicating the premium written and percent of rate change for each line of business. The RF-3 form must indicate whether the information is "exact" or "estimated."	Duplicate copies of RF-3 are attached. Completed – See the RF-3. This is not applicable. RF-3 indicates "estimated".
PAYMENT PLANS			

Quarterly premium payment installment plan required as prescribed by the Director.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois shall offer to each of its medical liability insureds the option to make premium payments in quarterly installments as prescribed by and filed with the Director. Such option must be offered in the initial offer of the policy or in the first policy renewal occurring after January 1, 2006. Thereafter, the insurer need not offer the option, but if the insured requests it, must make it available. Such plans are subject to the following minimum requirements: • May not require more than 40% of the estimated total premium to be paid as the initial payment; • Must spread the remaining premium equally among the 2nd, 3rd, and 4th installments, with the maximum set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively; • May not apply interest charges; • May include an installment charge or fee of no more than the lesser of 1% of the total premium or $25; • Must spread any additional premium resulting from changes to the policy equally over the remaining installments, if any. If there are no remaining installments, the additional premium may be billed immediately as a separate transaction; and • May, but is not required to offer payment plan for extensions of a reporting period, or to insureds whose annual premiums are less than $500. However, if offered to either, the plan must be made available to all within that group.	We comply with these requirements.
DEDUCTIBLES			
Deductible plans should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer the opportunity for participation in a plan offering deductibles to its medical liability insureds. Any such plan shall be contained in a filed rate/rule manual section entitled "Deductibles Offered" or substantially similar title. If an insurer uses a substantially similar title, the Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	See item XV titled Deductibles offered on page IL-10.
DISCOUNTS			
Premium discount for risk management activities should be filed if offered.	215 ILCS 5/155.18	A company writing medical liability insurance in Illinois is encouraged, but not required, to offer their medical liability insureds a plan providing premium discounts for participation in risk management activities. Any such plan shall be contained in a filed rate/rule manual section entitled "Risk Management Activities Discounts" or substantially similar title. If an insurer uses a substantially similar title, the	See item XVI titled Risk Management Activities Discounts on page IL-10.

		Rate/Rule Submission Letter or NAIC Uniform Transmittal form must indicate the name of the section that applies.	
CLAIMS MADE REQUIREMENTS			
Extended reporting period (tail coverage) requirements.	215 ILCS 5/143(2) Company Bulletin 88-50	When issuing claims-made medical liability insurance policies, insurers must include the following specific information in their rate/rule manuals: • Offer of an extended reporting period (tail coverage) of at least 12 months. The rate/rule manual must specify whether the extended reporting period is unlimited or indicate its term (i.e. number of years).*** • Cost of the extended reporting period, which must be priced as a factor of one of the following:*** o the last 12 months' premium. o the premium in effect at policy issuance. o the expiring annual premium. • List of any credits, discounts, etc. that will be added or removed when determining the final extended reporting period premium. • Insurer will inform the insured of the extended reporting period premium at the time the last policy is purchased. The insurer may not wait until the insured requests to purchase the extended reporting period coverage to tell the insured what the premium will be or how the premium would be calculated. • Insurer will offer the extended reporting period when the policy is terminated for any reason, including non-payment of premium, and whether the policy is terminated at the company's or insured's request. • Insurer will allow the insured 30 days after the policy is terminated to purchase the extended reporting period coverage.*** • Insurer will trigger the claims made coverage when notice of claim is received and recorded by the insured or company, whichever comes first. ***If the medical liability coverage is combined with other professional or general liability coverages, the medical liability insurer must meet all of the above requirements, except those indicated with ***, in which case, the insurer must: • Offer free 5-year extended reporting period (tail coverage) or	See Item I, Reporting Period Extension Rules on page IL-7. See Item I, Reporting Period Extension Rules and Item J. Reporting Period Extension Factors on page IL-7. We comply with this rule. See Item I Reporting Period Extension rules and Item J Reporting Period Extension Factors on page IL-7. See Item I. Reporting Period Extension Rules and Item J, Reporting Period Extension Factors on page IL-7. See Item I, Reporting Period Extension Rules, Page IL-7. This is not applicable in this area so disregard. We do not include general liability or other professional coverages so this is not applicable with our company.

		• Offer an unlimited extended reporting period with the limits reinstated (100% of aggregate expiring limits for the duration) • Cap the premium at 200% of the annual premium of the expiring policy; and • Give the insured a free-60 day period after the end of the policy to request the coverage.	
GROUP MEDICAL LIABILITY			
Group medical liability insurance is not specifically allowed under the Illinois Insurance Code.	50 IL Adm. Code 906	Part 906 of the Illinois Administrative Code prohibits writing of group casualty (liability) insurance unless specifically authorized by statute. The Illinois Insurance Code does not specifically authorize the writing of group medical liability insurance.	We are abiding by this rule.
CANCELLATION & NONRENEWAL PROVISION REQUIREMENTS			
If rate/rule manuals contain language pertaining to cancellation or nonrenewal, must comply with all cancellation/nonrenewal laws.	See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	If a rate or rule manual contains language pertaining to cancellation or nonrenewal of any medical liability insurance coverage, such provisions must comply with all cancellation and nonrenewal provisions of the Illinois Insurance Code, including but not limited to the following: 143.10, 143.16, 143.16a, 143.17a. See Medical Liability Forms Checklist for Specific Information about Illinois Cancellation & Nonrenewal Laws and Regulations,	No rate or rule in the manual contains language pertaining to cancellation or non-renewal.
ACTUARIAL REVIEW REQUIREMENTS			
Rates shall not be excessive, inadequate, or unfairly discriminatory.	215 ILCS 5/155.18	In the making or use of rates pertaining to all classes of medical liability insurance, rates shall not be excessive, or inadequate, nor shall they be unfairly discriminatory. Rate and rule manual provisions should be defined and explained in a manner that allows the Division to ascertain whether the provision could be applied in an unfairly discriminatory manner. For example, if a rate/rule manual contains ranges of premiums or discounts, the provision must specify the criteria to determine the specific premium/discount an insured or applicant would receive. The Director may, by order, adjust a rate or take any other appropriate action at the conclusion of a public hearing.	Rates being proposed with this filing are adequate, not excessive, and not unfairly discriminatory.
PRICING			

Insurers shall consider certain information when developing medical liability rates.	215 ILCS 5/155.18	Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to Illinois, and to all other factors, including judgment factors, deemed relevant within and outside Illinois. Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by companies to their policyholders, members or subscribers. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Our own experience is shown in Exhibits 2 through Exhibit 4. We also relied on ISMIE's specialty and territorial relativities in Exhibit 7a, 8a and Exhibit 9. Our expense assumptions are shown in Exhibit 5a, 5b, 5c, 5d and 5e.
Minimum Premium Rules			
Insurers may group or classify risks for establishing rates and minimum premiums.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Not applicable with this filing.
"A" RATED RISKS			
Individual Risk Rating			
Risks may be rated on an individual basis as long as all provisions required in Section 155.18 are met.	215 ILCS 5/155.18	Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Such classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, location or dispersion of hazard, or any other reasonable considerations, and shall apply to all risks under the same or substantially the same circumstances or conditions. The rate for an established classification should be related generally to the anticipated loss and expense factors or the class.	Not applicable with this filing.
RISK CLASSIFICATION			
Risks may be grouped by classifications.	215 ILCS 5/155.18	Risks may be grouped by classifications for the establishment of rates and minimum premiums.	Exhibit 7b shows specialty groupings used in this filing.
Rating decisions based solely on domestic violence.	215 ILCS 5/155.22b	No insurer may that issues a property and casualty policy may use the fact that an applicant or insured incurred bodily injury as a result of a battery committed against him/her by a spouse or person in the same household as a sole reason for a rating decision.	Not applicable with this filing. Domestic violence considerations are not part of our rating plan.

Unfair methods of competition or unfair or deceptive acts or practices defined.	215 ILCS 5/424(3)	It is an unfair method of competition or unfair and deceptive act or practice if a company makes or permits any unfair discrimination between individuals or risks of the same class or of essentially the same hazard and expense element because of the race, color, religion, or national origin of such insurance risks or applicants.	Not applicable with this filing. Our rating plan does not unfairly discriminate as defined by statute.
Procedure as to unfair methods of competition or unfair or deceptive acts or practices not defined.	215 ILCS 5/429	Outlines the procedures the Director follows when he has reason to believe that a company is engaging in unfair methods of competition or unfair or deceptive acts or practices.	Not applicable.
Territorial Definitions			
Rate/rule manuals must contain correct and adequate definitions of Illinois territories.	215 ILCS 5/155.18	When an insurer's rate/rule program includes differing territories within the State of Illinois, rate/rule manuals must contain correct and adequate definitions of those territories, and that all references to the territories or definitions are accurate, so the Division does not need to request additional information.	Page IL-1 of the Illinois exception manual.
ACTUARIAL SUPPORT INFORMATION REQUIRED			
ACTUARIAL CERTIFICATION			
Actuarial certification must accompany all rate filings and all rule filings that affect rates.	215 ILCS 5/155.18 50 IL Adm. Code 929 Actuarial Certification Form	Every rate and/or rating rule filing must include a certification by an officer of the company and a qualified actuary that the company's rates and/or rules are based on sound actuarial principles and are not inconsistent with the company's experience. Insurers may use their own form or may use the sample form created by the Division.	Included with this filing.
ACTUARIAL OR STATISTICAL INFORMATION			
Director may request actuarial and statistical information.	215 ILCS 5/155.18 50 IL Adm. Code 929	The Director may require the filing of statistical data and any other pertinent information necessary to determine the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, rates, forms or any combination thereof. If the Director requests information or statistical data to determine the manner the insurer used to set the filed rates and/or to determine the reasonableness of those rates, as well as the manner of promulgation and the acceptability or unacceptability of a filing for rules, minimum premiums, or any combination thereof, the insurer shall provide such data or information within 14 calendar days of the Director's request.	Not applicable with this filing.
Explanatory Memorandum			
Insurers shall include actuarial explanatory	215 ILCS 5/155.18	Insurers shall include actuarial explanatory memorandum with any rate filing, as well as any	Actuarial Memorandum

memorandum with any rate filing, as well as any rule filing that affects the ultimate premium.	50 IL Adm. Code 929	rule filing that affects the ultimate premium. The explanatory memorandum shall contain, at minimum, the following information: • Explanation of ratemaking methodologies. • Explanations of specific changes included in the filing. • Narrative that will assist in understanding the filing.	included.
Summary of Effects Exhibit			
Insurers shall include an exhibit illustrating the effect of each change and calculation indicating how the final effect was derived.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the effect of each individual change being made in the filing (e.g. territorial base rates, classification factor changes, number of exposures affected by each change being made, etc.), and include a supporting calculation indicating how the final effect was derived.	Exhibit 1.
Actuarial Indication			
Insurers shall include actuarial support justifying the overall changes being made.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support justifying the overall changes being made, including but not limited to: • Pure premiums (if used). • Earned premiums. • Incurred losses. • Loss development factors. • Trend factors. • On-Level factors. • Permissible loss ratios, etc.	Exhibit 2 through 6b.
Loss Development Factors and Analysis			
Insurers shall include support for loss development factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include actuarial support for loss development factors and analysis, including but not limited to loss triangles and selected factors, as well as support for the selected factors.	Exhibit 3b-1 through 3c-1.
Ultimate Loss Selections			
Insurers shall include support for ultimate loss selections.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for ultimate loss selections, including an explanation of selected losses if results from various methods differ significantly.	Exhibit 3a and footnotes plus actuarial memorandum.
Trend Factors and Analysis			
Insurers shall include support for trend factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for trend factors and analysis, including loss and premium trend exhibits demonstrating the basis for the selections used.	Exhibit 4.
On-Level Factors and Analysis			
Insurers shall include support for on-level factors and analysis.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for on-level factors and analysis, including exhibits providing on-level factors and past rate changes included in calculations.	Exhibit 10.
Loss Adjustment			

Expenses			
Insurers shall include support for loss adjustment expenses.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include support for loss adjustment expenses, including exhibits providing documentation to support factors used for ALAE and ULAE. If ALAE is included in loss development analysis, no additional ALAE exhibit is required.	ALAE included in development Exhibit 3b through 3c. ULAE shown in Exhibit 5c.
Expense Exhibit			
Insurers shall include an expense exhibit. Insurers may use expense provisions that differ from those of other companies or groups of companies.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit indicating all expenses used in the calculation of the permissible loss ratio, including explanations and support for selections. The systems of expense provisions included in the rates for use by any company or group of companies may differ from those of other companies or groups of companies to reflect the operating methods of any such company or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.	Exhibit 5c and 5d.
Investment Income Calculation			
Insurers shall include an exhibit for investment income calculation.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit demonstrating the calculation for the investment income factor used in the indication.	Exhibit 6a and 6b.
Profit and Contingencies Calculation			
Insurers shall include an exhibit for profit and contingencies load.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall include an exhibit illustrating the derivation of any profit and contingencies load.	Exhibit 5e.
Credibility Standard Used			
Insurers shall include the number of claims being used to calculate the credibility factor.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include the number of claims being used to calculate the credibility factor. If another method of calculating credibility is utilized, insurers should include a description of the method used.	$Z = P / (P + K)$ as indicated in actuarial memorandum.
Other Actuarial Information Required			
Insurers must include the information described in this section.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers shall also include the following information: • All actuarial support/justification for all rates being changed, including but not limited to changes in: o Base rates; o Territory definitions; o Territory factor changes; o Classification factor changes; o Classification definition changes; o Changes to schedule credits/debits, etc. • Exhibits containing current and proposed rates/factors for all rates and classification factors, etc. being changed.	Exhibits 7a, 8a and 9.

		• Any exhibits necessary to support the filing that are not mentioned elsewhere in this checklist.	
Schedule Rating			
Insurers must include the described information described at right.	215 ILCS 5/155.18 50 IL Adm. Code 929	Insurers should include appropriate actuarial justification when filing schedule rating plans and/or changes to schedule rating plans.	Not applicable

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XII. RATES, STATE RULES EXCEPTIONS--Illinois

A. Illinois Rating Territories

Territory Code	Territory Description	Territory Factor
1	Cook, Madison and St. Clair Counties	1.000
2	Jackson, Vermilion and Will Counties	0.890
3	DuPage, Kane, Lake, McHenry and Winnebago Counties	0.800
4	Champaign, Macon and Sangamon Counties	0.630
5	Bureau, Coles, DeKalb, Kankakee, LaSalle, Ogle and Randolph Counties	0.720
6	Remainder of State	0.530
7	Peoria County	0.470

B. Mature Claims-Made Rates - Countrywide Manual Section II. General Rules, Rule A. Rates – is amended to read: Premiums are calculated by using the mature claims-made base rates, as shown below with limits of $1,000,000/$4,000,000 and by applying applicable claims-made maturity factors or other coverage option factors.

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
229		Addictionology	18,703	16,645	14,962	11,783	13,466	9,912	8,790
230		Aerospace Medicine	24,231	21,565	19,385	15,265	17,446	12,842	11,388
254		Allergy	17,349	15,441	13,879	10,930	12,491	9,195	8,154
151		Anesthesiology	41,530	36,962	33,224	26,164	29,902	22,011	19,519
196		Anesthesiology – Pain Management	41,530	36,962	33,224	26,164	29,902	22,011	19,519
255		Cardiovascular Disease – No Surgery	28,631	25,482	22,905	18,038	20,615	15,175	13,457
281		Cardiovascular Disease - Minor Surgery	59,659	53,097	47,727	37,585	42,955	31,619	28,040
256		Dermatology	20,790	18,503	16,632	13,098	14,969	11,019	9,771
282		Dermatology – Minor Surgery	37,497	33,373	29,998	23,623	26,998	19,874	17,624
237		Diabetes – No Surgery	26,946	23,982	21,557	16,976	19,401	14,281	12,665
271		Diabetes – Minor Surgery	39,821	35,441	31,857	25,087	28,671	21,105	18,716
102	S	Emergency Medicine – No Major Surgery	99,326	88,400	79,461	62,575	71,515	52,643	46,683
238		Endocrinology – No Surgery	25,678	22,853	20,542	16,177	18,488	13,609	12,068
272		Endocrinology – Minor Surgery	37,945	33,771	30,356	23,906	27,321	20,111	17,834

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Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
420		Family/General Practitioners – No Surgery	34,973	31,126	27,978	22,033	25,181	18,536	16,437
421		Family/General Practitioners – Minor Surgery	46,692	41,556	37,354	29,416	33,618	24,747	21,945
521		Family/General Practitioners –Minor Surgery – 0 to 24 deliveries	47,432	42,215	37,946	29,882	34,151	25,139	22,293
240		Forensic or Legal Medicine	16,963	15,097	13,570	10,686	12,213	8,990	7,972
241		Gastroenterology – No Surgery	43,206	38,454	34,565	27,220	31,109	22,899	20,307
274		Gastroenterology – Minor Surgery	46,076	41,007	36,860	29,028	33,174	24,420	21,655
231		General Preventive Medicine – No Surgery	15,933	14,180	12,746	10,038	11,472	8,444	7,488
243		Geriatrics – No Surgery	27,381	24,369	21,905	17,250	19,714	14,512	12,869
276		Geriatrics – Minor Surgery	40,464	36,013	32,371	25,492	29,134	21,446	19,018
244		Gynecology – No Surgery	26,562	23,640	21,250	16,734	19,125	14,078	12,484
277		Gynecology – Minor Surgery	42,589	37,905	34,072	26,831	30,664	22,572	20,017
245		Hematology – No Surgery	34,973	31,126	27,978	22,033	25,181	18,536	16,437
278		Hematology – Minor Surgery	49,603	44,147	39,682	31,250	35,714	26,290	23,313
232		Hypnosis	16,562	14,740	13,250	10,434	11,925	8,778	7,784
246		Infectious Diseases – No Surgery	50,711	45,132	40,568	31,948	36,512	26,877	23,834
279		Infectious Diseases – Minor Surgery	79,933	71,140	63,946	50,358	57,551	42,364	37,568
283		Intensive Care Medicine/Hospitalist	38,772	34,507	31,018	24,426	27,916	20,549	18,223
257		Internal medicine – No Surgery	41,066	36,548	32,853	25,871	29,567	21,765	19,301
284		Internal medicine – Minor Surgery	53,464	47,583	42,771	33,682	38,494	28,336	25,128
258		Laryngology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
285		Laryngology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278
801		Manipulative Medicine	17,450	15,530	13,960	10,993	12,564	9,248	8,201
471		Neonatology - No Surgery	60,567	53,905	48,454	38,157	43,608	32,100	28,466
476		Neonatology – Minor Surgery	75,710	67,382	60,568	47,697	54,511	40,126	35,584
259		Neoplastic Diseases – No Surgery	35,523	31,615	28,418	22,379	25,576	18,827	16,696
260		Nephrology – No Surgery	31,476	28,014	25,181	19,830	22,663	16,682	14,794
287		Nephrology – Minor Surgery	46,515	41,399	37,212	29,305	33,491	24,653	21,862
261		Neurology – No Surgery	42,104	37,473	33,683	26,526	30,315	22,315	19,789
288		Neurology – Minor Surgery	49,989	44,490	39,991	31,493	35,992	26,494	23,495
262		Nuclear Medicine	25,581	22,767	20,465	16,116	18,418	13,558	12,023
248		Nutrition	15,022	13,369	12,017	9,464	10,816	7,961	7,060
233		Occupational Medicine	20,192	17,971	16,154	12,721	14,538	10,702	9,490
473		Oncology – No Surgery	35,523	31,615	28,418	22,379	25,576	18,827	16,696
286		Oncology – Minor Surgery	43,745	38,933	34,996	27,559	31,496	23,185	20,560
263		Ophthalmology – No Surgery	23,763	21,149	19,010	14,971	17,109	12,594	11,168
289		Ophthalmology – Minor Surgery	25,823	22,983	20,659	16,269	18,593	13,686	12,137
264		Otology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
290		Otology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278

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Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
265		Otorhinolaryngology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
291		Otorhinolaryngology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278
266		Pathology – No Surgery	27,602	24,566	22,082	17,390	19,874	14,629	12,973
292		Pathology – Minor Surgery	48,250	42,943	38,600	30,398	34,740	25,573	22,678
267		Pediatrics – No Surgery	27,698	24,651	22,159	17,450	19,943	14,680	13,018
293		Pediatrics – Minor Surgery	41,229	36,693	32,983	25,974	29,685	21,851	19,377
234		Pharmacology	24,231	21,565	19,385	15,265	17,446	12,842	11,388
235		Physiatry or Physical Medicine and Rehabilitation	17,450	15,530	13,960	10,993	12,564	9,248	8,201
437		Physicians – No Major Surgery – acupuncture	43,745	38,933	34,996	27,559	31,496	23,185	20,560
802		Physicians – No Major Surgery – Sclerotherapy	47,672	42,428	38,138	30,034	34,324	25,266	22,406
431		Physicians – No Major Surgery – shock therapy	47,672	42,428	38,138	30,034	34,324	25,266	22,406
268		Physicians – not otherwise classified – no surgery	28,039	24,955	22,431	17,665	20,188	14,861	13,178
294		Physicians – not othewise classified – minor surgery	43,745	38,933	34,996	27,559	31,496	23,185	20,560
249		Psychiatry	19,577	17,424	15,662	12,334	14,096	10,376	9,201
250		Psychoanalysis	18,296	16,283	14,637	11,526	13,173	9,697	8,599
251		Psychosomatic Medicine	14,770	13,146	11,816	9,305	10,635	7,828	6,942
236		Public Health	16,963	15,097	13,570	10,686	12,213	8,990	7,972
269		Pulmonary Diseases – No Surgery	36,216	32,232	28,972	22,816	26,075	19,194	17,021
298		Pulmonary Diseases – Minor Surgery	61,753	54,960	49,403	38,905	44,462	32,729	29,024
253	S	Radiology – diagnostic – No Surgery	43,268	38,508	34,614	27,259	31,153	22,932	20,336
280	S	Radiology – diagnostic – Minor Surgery	65,837	58,595	52,670	41,477	47,403	34,894	30,943
425	S	Radiology – Therapeutic	48,910	43,530	39,128	30,813	35,215	25,922	22,988
252		Rheumatology – No Surgery	26,236	23,350	20,989	16,529	18,890	13,905	12,331
247		Rhinology – No Surgery	19,294	17,172	15,435	12,155	13,892	10,226	9,068
270		Rhinology – Minor Surgery	43,145	38,399	34,516	27,182	31,065	22,867	20,278
166	S	Surgery – Abdominal	99,148	88,242	79,318	62,463	71,386	52,548	46,599
101	S	Surgery – Broncho-esophagology	50,336	44,799	40,269	31,712	36,242	26,678	23,658
141	H	Surgery – Cardiac	154,358	137,379	123,486	97,245	111,138	81,810	72,548
150	H	Surgery – Cardiovascular Disease	141,068	125,550	112,854	88,873	101,569	74,766	66,302
115	S	Surgery – Colon and Rectal	66,351	59,052	53,081	41,801	47,773	35,166	31,185
472	S	Surgery – Dermatology	50,971	45,365	40,777	32,112	36,699	27,015	23,957
157	S	Surgery – Emergency Medicine	110,140	98,025	88,112	69,388	79,301	58,374	51,766
103	S	Surgery – Endocrinology	43,943	39,109	35,154	27,684	31,639	23,290	20,653
117	S	Surgery – Family/General Practice	64,564	57,462	51,651	40,676	46,486	34,219	30,345
104	S	Surgery – Gastroenterology	61,371	54,620	49,096	38,663	44,187	32,526	28,844
143	S	Surgery – General – not otherwise classified	92,067	81,939	73,653	58,002	66,288	48,795	43,271
105	S	Surgery – Geriatrics	64,705	57,587	51,764	40,764	46,587	34,293	30,411
167	H	Surgery – Gynecology	71,422	63,565	57,137	44,996	51,424	37,854	33,568
169	S	Surgery – Hand	64,413	57,328	51,530	40,580	46,377	34,139	30,274
170	S	Surgery – Head and Neck	79,367	70,636	63,493	50,001	57,144	42,064	37,302
106	S	Surgery - Laryngology	59,041	52,546	47,233	37,196	42,509	31,292	27,749

American Physicians Assurance Corporation

Health Care Providers Professional Liability Insurance

Illinois

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
474	H	Surgery – Neonatology or Pediatrics	106,511	94,794	85,208	67,102	76,688	56,451	50,060
107	S	Surgery – Neoplastic	55,916	49,765	44,733	35,227	40,260	29,636	26,281
108	S	Surgery – Nephrology	59,393	52,860	47,514	37,418	42,763	31,478	27,915
152	H	Surgery – Neurology	244,420	217,533	195,536	153,984	175,982	129,542	114,877
168	H	Surgery – Obstetrics	128,387	114,264	102,709	80,884	92,438	68,045	60,342
153	H	Surgery – Obstetrics – Gynecology	128,387	114,264	102,709	80,884	92,438	68,045	60,342
560	H	Surgery – Obstetrics – Gynecology – 0 to 49 deliveries	102,715	91,416	82,172	64,710	73,955	54,439	48,276
561	H	--50 to 69 deliveries	105,919	94,268	84,735	66,729	76,262	56,137	49,782
562	H	--70 to 89 deliveries	109,127	97,123	87,302	68,750	78,572	57,837	51,290
563	H	-- 90 to 109 deliveries	115,548	102,838	92,438	72,795	83,195	61,240	54,308
564	H	--110 to 129 deliveries	121,970	108,553	97,576	76,841	87,818	64,644	57,326
565	H	--130 to 149 deliveries	128,387	114,264	102,709	80,884	92,438	68,045	60,342
566	H	--150 to 169 deliveries	141,226	125,691	112,980	88,972	101,682	74,850	66,376
567	H	--170 to 189 deliveries	154,065	137,118	123,252	97,061	110,927	81,654	72,410
568	H	--190 to 209 deliveries	166,902	148,542	133,521	105,148	120,169	88,458	78,444
569	H	--210 to 229 deliveries	179,743	159,971	143,794	113,238	129,415	95,264	84,479
570	H	--230 to 249 deliveries	192,579	171,395	154,063	121,325	138,657	102,067	90,512
571	H	--250 to 269 deliveries	205,418	182,822	164,334	129,413	147,901	108,871	96,546
572	H	--270 to 289 deliveries	218,259	194,250	174,607	137,503	157,146	115,677	102,582
573	H	--290 to more deliveries	231,095	205,675	184,876	145,590	166,389	122,481	108,615
114	S	Surgery – Ophthalmology	45,753	40,721	36,603	28,825	32,942	24,249	21,504
804	S	Surgery – Ophthalmology – Plastic	59,866	53,281	47,893	37,716	43,104	31,729	28,137
154	H	Surgery – Orthopedic	157,096	139,816	125,677	98,971	113,109	83,261	73,835
164	H	Surgery – Orthopedic – without procedures on the back	115,759	103,026	92,607	72,928	83,347	61,352	54,407
158	S	Surgery – Otology	59,041	52,546	47,233	37,196	42,509	31,292	27,749
159	S	Surgery – Otorhinolaryngology	59,041	52,546	47,233	37,196	42,509	31,292	27,749
156	H	Surgery – Plastic – not otherwise classified	94,692	84,276	75,753	59,656	68,178	50,187	44,505
155	S	Surgery – Otorhinolaryngology	89,669	79,805	71,735	56,491	64,561	47,524	42,144
160	S	Surgery – Rhinology	59,041	52,546	47,233	37,196	42,509	31,292	27,749
144	H	Surgery – Thoracic	129,202	114,990	103,362	81,397	93,026	68,477	60,725
171	H	Surgery – Traumatic	128,187	114,086	102,550	80,758	92,295	67,939	60,248
145	S	Surgery – Urological	60,014	53,412	48,011	37,809	43,210	31,807	28,207
146	H	Surgery – Vascular	146,709	130,571	117,367	92,427	105,630	77,756	68,953
424		Urgent Care Medicine	34,973	31,126	27,978	22,033	25,181	18,536	16,437

Note: When $2,000,000/$4,000,000 Increased Limits Factor (ILF) is requested for a specialty code that displays an alpha code, either **S** or **H,** use the corresponding ILF factor as displayed in Rule F.

C. Mature Claims-Made Rates – Dentists

Specialty Code	ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
212		Dental Surgeons – Oral or Maxillofacial – Engaged in oral surgery or operative dentistry on patients rendered unconscious through the administering of any anesthesia or analgesia	38,655	34,403	30,924	24,353	27,832	20,487	18,168
210		Dentists – Minor Surgery	19,329	17,202	15,463	12,177	13,917	10,244	9,084
211		Dentists – No Surgery - not otherwise classified	7,731	6,881	6,185	4,871	5,566	4,097	3,634

D. Mature Claims-Made Rates – Healthcare Facilities

1. Emergency Room Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr. 7
S	Emergency Room Groups ("Per 100 patient visits" basis). Separate limits per member physician/healthcare professional may be purchased for an additional 20% charge of the "per patient visit" premium.	1,993	1,774	1,594	1,256	1,435	1,056	937

2. Urgent Care Groups*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
	Urgent Care Groups ("Per 100 patient visits" basis). Separate limits per member physician/healthcare professional may be purchased for an additional 20% charge of the "per patient visit" premium.	560	498	448	353	403	297	263

3. Outpatient Surgery Centers*

ILFs Alpha Code	Specialty Description	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
S	Outpatient Surgery Centers (Surgicenters) ("Per 100 patient visits" basis). All physicians must be separately insured by American Physicians in order to provide coverage for the outpatient surgery center.	2,833	2,521	2,266	1,785	2,040	1,501	1,331

4. Additional Healthcare Facility Rates (per $1000 receipts basis)*

ILFs Alpha Code	Specialty Description/Code	Terr. 1	Terr. 2	Terr. 3	Terr. 4	Terr. 5	Terr. 6	Terr.7
	X-Ray / Imaging Laboratory/Code 88526	7.43	7.43	7.43	7.43	7.43	7.43	7.43

*Note: Minimum premium for each Facility Policy in Section D., Item 1, 2, 3, and 4 is $2,500.

E. Premium Charges for Vicarious, Shared and Separate Limits
Under Countrywide Rule IX., Item D., Premium Charges for Vicarious, Shared and Separate Limits is replaced in its entirety with the following:

Specialty Code	Healthcare Professional	Vicarious Limit Charge	Shared Limit Charge	Separate Limit Charge
411	Chiropractor	0%	35% of class 420	70% of class 420
452	Nurse Anesthetist	0%	7.5% of class 151	15% of class 151
962	Nurse Midwife	0%	25% of class 153	50% of class 153
963	Nurse Practitioner	0%	7.5% of class 420	15% of class 420
942	Perfusionist	0%	7.5% of class 420	15% of class 420
807	Physician Assistant	0%	7.5% of class 420	15% of class 420
943	Podiatrist/incl. surg.	0%	40% of class 143	50% of class 143
944	Podiatrist – no surg.	0%	35% of class 420	70% of class 420
946	Psychologist	0%	5% of class 249	10% of class 249
808	Surgeon Assistant	0%	7.5% of class 420	15% of class 420

F. Higher limits of liability may be purchased at premiums derived by applying the following factors to the $1,000,000/$4,000,000 rates:

Higher Limits of Liability	All Other Physicians and Dentists	Emergency Medicine, Radiologists, All Other Surgery **(S)**	Selected Surgical Specialties **(H)**
$2,000,000/$4,000,000	1.344	1.418	1.460

For higher Limits of Liability – Refer to Company

G. Limits that are less than these $1,000,000/$4,000,000 may be purchased at premiums derived from applying the following decreased limit factors to the $1,000,000/$4,000,000 rates (not including any credit applied for a deductible):

Limits of Liability	All Physicians, Surgeons, and Dentists
$100,000/$400,000	0.480
$200/000/$800,000	0.620
$250,000/$1,000,000	0.665
$300,000/$1,200,000	0.700
$500,000/$2,000,000	0.790
$750,000/$3,000,000	0.920
$1,000,000/$2,000,000	0.980
$1,000,000/$4,000,000	1.000

H. Claims-Made Maturity Factors

Note: If the retroactive date falls on a date other than the anniversary date, a factor will be used that is pro-rating the two applicable maturity factors. These factors are applied to the mature claims-made base rates.

First Year	0.25
Second Year	0.40
Third Year	0.75
Fourth Year	0.90
Fifth Year	0.95
Sixth Year	0.98
Mature	1.00

I. Reporting Period Extension Factors

Claims-made reporting period extension(s) ("tail" coverage) are offered (unless coverage is automatically provided within the terms of the policy) to any insured whose coverage is terminated for any reason.

1. A single extension for an unlimited reporting period may be purchased. One set of limits of liability is provided for the entire unlimited reporting period. The rates for this extension are computed by applying the applicable reporting period extension factor displayed below to the annual expiring premium.

2. Alternatively, three extensions may be purchased as of the policy termination and the next two anniversaries of that termination. Separate limits apply for each of the three extensions. The final extension is an unlimited extension. Premiums for each extension are 33.3% of the rate applicable to the single unlimited extension (1.).

J. Factors are applied to the claims-made rate applicable to the annual expiring policy at the time the extended reporting endorsement is offered.

First Year	4.00
Second Year	3.88
Third Year	2.40
Fourth Year	2.11
Fifth Year	2.05
Sixth Year	2.01
Mature	1.97

K. Corporate Entity Coverage

Under Countrywide Corporate Entity Coverage Rule, Item B. Organization Coverage Charge – Separate Limits, sub item 3. is replaced with the following:

3.

# of Insureds	Charge
2-5	15.0%
6-9	12.0%
10-19	9.0%
20 or more	7.0%

L. Part-Time Rule

Under Countrywide Rule VI. Special Rating Rules, Item A. Part Time is replaced with the following:

A. Part Time: 60% of the otherwise applicable rate applies to physicians (see eligibility requirements under General Rules) with American Physicians insured exposure averaging 20 hours or less per week. If evidence of insurance is provided for any professional liability exposure insured by any other carrier, that other exposure would be excluded from the American Physicians policy. Other credits may be reduced due to lower premiums with this rating.

XIII. Merit Rating

In order to be eligible for any merit-rating plan, the incurred loss ratio over the last 10 years shall not exceed **135%**. The total credit that may be applied under the Claims-Free Credit Rule is **-15%**, the total credit/debit that may be applied under the Schedule Rating Plan is **+/- 25%**, and the total credit that may be applied under the Risk Management Premium Plan is **-10%**.

A. Claim-Free Credit
See countrywide manual Section X. Merit Rating, Rule A. for the underwriting criteria. Below is the Claim-Free Credit Schedule for use in Illinois:

1. Credit Schedule:

Years of Claims-Free Experience	Credit
Three to Five Years	5%
Six to Seven Years	10%
Eight or More Years	15%

B. Schedule Rating Plan

The premium may be credited or debited based on the total of credits and debits derived from the following "risk characteristics" schedule. The maximum allowable credit/debit for the Schedule Rating Plan is **+/- 25%.**

	Maximum Credit	Maximum Debit
1. Professional Skills, Quality of Care Use of a recognized system of clinical guidelines. Relevant board certification. Accreditation status by a recognized regulatory body. The provision of medical care limited to qualified individuals. Continuing education of all professional staff beyond what is required by state licensing regulation. Maintenance of premises and equipment.	10%	10%
2. Patient Rapport Length of service and reputation in community. Established policies and procedures for patient services. Cooperation with the Company claims management and resolution procedures.	10%	10%
3. Record Keeping A well-maintained patient record system in place: thorough documentation of patient care and interaction; follow-up system for diagnostic studies, consultation and appointments.	10%	10%

C. Risk Management Premium Credits

Insureds who participate in risk management activities approved by the Company are eligible for the following premium credit up to a maximum of 10%:

1. Individual Risk Management Activities – Individual insureds may receive premium credit as indicated for completion of the following activities:

	Credit
a. Successful completion of a risk management onsite visit by company risk consultants with an acceptable grading and completion of recommendations or an agreed upon plan to complete recommendations.	0% to 10%

b. Continuing education in risk management through company online programs or other CME approved programs 0% to 5%

XIV. Quarterly Installment Option and Monthly Installment Option

American Physicians offers the following: (does not apply to Claims-Made Reporting Period Extensions ("tail coverage").

4-pay (quarterly)	25% down payment	3 equal installments (Due 4th, 7th, and 10th months).
9-pay (monthly)	15% down payment	8 equal installments (Due 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, and 9th months).

- A $10 installment fee will be applied to all payment plans/per installment. No interest will be charged.

XV. Deductibles

See Countrywide Manual, Section V. for underwriting criteria.
Item C. from the Deductible section in the Countrywide Manual is deleted and replaced with the following: Deductible factors are applied to the $1,000,000/$4,000,000 base rate, Section IV, Rating Steps, Item D to derive the deductible credit amount.

Deductible Amount Per Incident	Indemnity Only Factor	Indemnity and Defense Factor
$5,000	.01	.03
$10,000	.03	.05
$15,000	.04	.08
$25,000	.07	.12
$30,000	.08	.13
$50,000	.12	.19
$75,000	.16	.25
$100,000	.19	.30
$200,000	.27	.43

XVI. Risk Management Activities Discounts

See Section XIII. Merit Rating, Rule B., Schedule Rating Plan, item C – Risk Characteristics on page IL-9 for the Underwriting Criteria.

XVII. Consent to Rate

Under Countrywide Rules, Rule XI. Consent to Rate is deleted in its entirety.